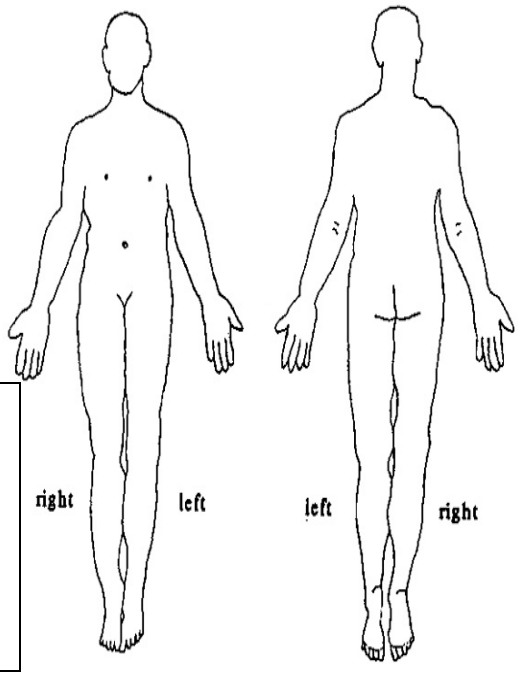
Interventional Pain Management Clinic
National Naval Medical Center

Follow-up Assessment Tool

Name:	Date:
Sponsor SS#:	Age:
Home Phone:	Work Phone
Referring Doctor:	Primary Doctor:

BP	
PULSE	
Sp02	
TOBACCO USE	
ALCOHOL	

Please mark the location of your pain on the diagram below.



My pain affects my:
(Mark all that apply)

- ☐ Ability to work
  - Hrs. you work per day ___
- ☐ Ability to Sleep
  - Hrs. of sleep per night___
  - ☐ Interrupted
  - ☐ Uninterrupted
  - ☐ Use sleep medication
- ☐ Recreational activities
- ☐ Daily Activities
- ☐ Relationship with family
- ☐ Relationship with friends
- ☐ Concentration
- ☐ Emotions: I am frequently:
  - ☐ Angry
  - ☐ Tearful
  - ☐ Sad
  - ☐ Suicidal

Have you been deployed since September 11th 2001?

☐ Yes ☐ No

Could the reason for your visit today in some way be related to your deployment?

☐ Yes ☐ No

Pain Severity

Today:

No Pain — Worst Pain

0 1 2 3 4 5 6 7 8 9 10

Average day:

0 1 2 3 4 5 6 7 8 9 10

Worst in the last 2 weeks:

0 1 2 3 4 5 6 7 8 9 10

Best in last 2 weeks:

0 1 2 3 4 5 6 7 8 9 10

Energy Level over past week:

0 1 2 3 4 5 6 7 8 9 10

Since my last visit my pain has:

- ☐ Improved
- ☐ Stayed the same
- ☐ Worsened

The treatment or medication I received at my last visit:

- ☐ Helped my pain
- ☐ Did not change my pain
- ☐ Worsened my pain

Since I have been treated in the pain clinic, overall I am doing:

- ☐ Better
- ☐ The same
- ☐ Worse